Medi-Cal

Focus: Managed Care

Moving toward a shared future

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SURVIVAL TIPS IN A MANAGED CARE ENVIRONMENT

Medi-Cal is expanding an alternate delivery system called Managed Care. Examining who you are as a Medi-Cal provider, what services you provide, and how your services may be reimbursed, can prepare you to more effectively function in the Managed Care environment.

WHO AM I?

First identify your provider type and whether your business or practice includes many different professionals or disciplines.

WHAT DO I PROVIDE?

Next, identify how you may have bundled your services and products when billing under Medi-Cal Fee-For-Service (FFS). Treatments, equipment, medications and medical supplies should be itemized in this analysis as each may be considered differently by the various types of managed care models operating in California.

WHO IS MY CUSTOMER?

Third, identify your customer and their health plan. Verify Medi-Cal eligibility at every encounter. In many cases, a member of a health plan may be assigned to an affiliate of the Medi-Cal contracted plan known as a plan partner or a medical group that is delegated the responsibility of "Gate Keeper." Client circumstances, Medi-Cal eligibility and authorization arrangements can change unexpectedly.

Generally, full scope Medi-Cal benefits are covered services of a managed care plan. Excluded (carve out) services are billed FFS. A list of your services must be individualized for each health plan to know if the particular service is a health plan covered service or an excluded service. Services subject to out-of-plan access rules (which must be reimbursed by a managed care plan without prior authorization) include **family planning services, treatment for specific sexually transmitted diseases, HIV testing and counseling, and emergency services.** If your services fall into these four special access categories, you may not need a contract to bill the health plan for these services, but will need to develop a relationship with each health plan whose

(see Survival Tips in a Managed Care Environment, page 2)

Medi-Cal **is published quarterly by the California Department of Health Services, Medi-Cal Payment Systems Division, to inform Fee-for-Service Medi-Cal Providers about current trends impacting the Medi-Cal program. Our focus for the first series of issues will be Managed Care.**

THIS MONTH

SURVIVAL TIPS IN A MANAGED CARE ENVIRONMENT (*continued*)

WHERE DO I BILL ?

members you encounter. This is important so that both you and the health plan understand the processes for effective exchange of information, avoiding duplication of services, promoting continuity of care, and insuring your timely reimbursement.

Always retain your ability to bill FFS.

When a particular service is an excluded service, you will obtain prior authorization when needed from the appropriate Field Office and submit claims to Electronic Data Systems (EDS), the fiscal intermediary. Always retain your ability to bill FFS, as eligibility and plan membership can change retroactively and your claim may occassionally need to be redirected to EDS.

LOS ANGELES COUNTY MANAGED CARE

On September 30, 1997, the Health Care Financing Administration (HCFA) approved the resumption of mandatory enrollment in Los Angeles County, meaning that Medi-Cal beneficiaries with a mandatory enrollment aid code are required to choose between two authorized health plans. Those who make no choice will be assigned to either L.A. Care Health Plan (local initiative) or Foundation Health (commercial plan). To assist beneficiaries in making a choice, informing and educational activities were undertaken emphasizing the importance of, and process for, choosing a health plan. Concurrently, Fee-For-Service (FFS) is eliminated as a health care delivery option for beneficiaries with a mandatory aid code unless they qualified for an exemption from mandatory enrollment.

Initially, beneficiaries who do not make a choice will be assigned exclusively to L.A. Care, which in turn will distribute members among its plan partners. After L.A. Care reaches a minimum level, the remaining beneficiary non-choice assignments will be distributed between L.A. Care and Foundation. The first non-choice assignments were effective with the January 1998 month of eligibility. It is expected to take approximately six months to convert the estimated 600,000 remaining beneficiaries with a mandatory aid code from FFS to managed care.

The State has taken several steps to ensure a smooth transition from FFS to managed care. The enrollment contractor (MAXIMUS) has acquired additional mail room, key data entry and telephone services staff in anticipation of a larger volume of calls. Additional presentation sites were established in Los Angeles County to help explain to eligible beneficiaries their choices for receiving Medi-Cal benefits, how to a access staff and informational resources, and to answer questions about managed care. Beneficiary enrollment materials were extensively revised, making them more readable and understandable. These materials were translated into ten languages. Finally, media campaign activities were initiated which included the use of radio spots and outdoor posters announcing the change in the way Medi-Cal services will be provided.

HEALTHY FAMILIES

During the 1996/97 legislative session, Assembly Bills 1572, 1126, 217 and Senate Bill 903 were passed creating the California Children's Health Plan program (now called *"Healthy Families"*). This is a comprehensive, subsidized health insurance program for uninsured children 1 through 18 years of age, whose family income is between 100% – 200% of the federal poverty level (FPL) and who are ineligible for no-cost Medi-Cal. These children (an estimated 580,000) lack health insurance coverage resulting in restricted access to primary and preventive care and increased reliance on emergency rooms and hospitals for treatment.

Healthy Families, scheduled to begin on July 1, 1998, will offer comprehensive health, dental and vision benefits. The program is designed to be closely coordinated with a number of existing programs serving low income children to ensure a seamless delivery system and continuity of care. A simple mail-in application process will be used to determine the child's eligibility, and families will be able to select a health, dental and vision plan best meeting the needs of their children.

The majority of children participating in *Healthy Families* will receive coverage through a purchasing pool that operates similarly to successful employer-sponsored purchasing cooperatives currently operating in California, such as the California Public Employees Retirement System and the Health Insurance Plan of California. Families contribute toward the cost of coverage by paying a modest premium calculated on a sliding scale and through copayments for services which are not preventive in nature.

To allow families moving off of Medi-Cal to enroll into the *Healthy Families* program, Medi-Cal will provide transitional health care coverage for one month. Benefit and copayment levels will be set to help families make the transition from the full service, no-cost Medi-Cal program to the cost sharing levels in the employer-based market. Children eligible for a parent's employer-based dependent coverage may qualify for insurance purchasing credits to defray the cost of coverage.

The administration and policy oversight for *Healthy Families* will be provided by the Managed Risk Medical Insurance Board (MRMIB).

for information...

ELECTRONIC DATA SYSTEMS

Provider Support Center ..... (800) 541-5555

Beneficiary Telephone & Correspondence ..... (916) 636-1980
Point of Service Help Desk ..... (916) 636-1990
Computer Media Claims Help Desk ..... (916) 636-1100

DEPARTMENT OF HEALTH SERVICES

Managed Care Division ..... (916) 654-8076
Ombudsman ..... (888) 452-8609

Payment Systems Division
Provider Enrollment Unit ..... (916) 323-1945
Health Care Options Enrollment Contractor (MAXIMUS) ..... (800) 430-4263

QUESTIONS & ANSWERS

Can a health plan deny payment because of no prior authorization?

Yes. Managed care health plans enter into provider subcontracts (individual, group and/or integrated delivery systems) which include conditions for payment. When a provider becomes part of a health plan's network, the provider receives a manual describing procedures to follow. These procedures include steps for obtaining prior authorization when providing specific health care services in order for a claim to be considered for reimbursement.

Can a health plan "downcode and/or upcode" my claim after a records review?

The plan is responsible for reviewing claims received from all of their providers. The review is to assure that claims meet the criteria for medical necessity and that procedure codes billed are appropriate to the description. If the claim documentation shows that it does not meet the criteria for medical necessity or the claim code does not match the service being billed, the claim is adjusted accordingly. The health plan should communicate the difference with their providers when adjusting the claim.

Do you have a specific question regarding Medi-Cal that you would like to see answered in a future issue?

Please write to:

Department of Health Services
Medi-Cal Payment Systems Division
Provider Services Section
Medi-Cal Newsletter
714 P Street, Room 950
P.O. Box 942732
Sacramento, California 94234-7320

SPECIALTY MENTAL HEALTH SERVICES

On November 1, 1997, the State Department of Mental Health began implementation of the Specialty Mental Health Services Consolidation (MHSC) Program in Alameda, Kern, Placer, Riverside and San Joaquin counties. This program expands the Psychiatric Inpatient Hospital Services Consolidation Program that began in January 1995.

Under the MHSC program, Medi-Cal recipients will receive Specialty Mental Health services from a Mental Health Plan (MHP) in each of California's 58 counties, with the exception of San Mateo and Solano. All Medi-Cal recipients are enrolled automatically and will receive services from the MHP established in their respective county if they have a qualifying psychiatric condition. In most cases, the MHP is the county mental health department.

Specialty mental health services are covered by MHPs when they are delivered by a licensed specialty mental health provider: Physicians with a psychiatric specialty designation on the Medi-Cal provider master file; Psychologists; Early and Periodic Screening Diagnosis and Treatment (EPSDT) providers - Licensed Clinical Social Workers; Marriage, Family and Child Counselors; and Registered Nurses. Complete information on covered diagnoses and procedure codes may be found in the September 1997 *Medi-Cal Update*.

MHPs are responsible for the authorization and payment of all medically necessary specialty mental health services in accordance with Federal and State Medicaid requirements. They must maintain a 24-hour toll-free telephone number with information on plan services to recipients and providers. MHPs have the option to contract with selected providers to deliver services and must establish authorization and utilization review procedures. A provider handbook explaining the authorization process must be made available.

The following services are *excluded* from MHP coverage:

- California Children Services or Genetically Handicapped Persons Program
- Child Health and Disability Prevention Program and Children's Treatment Program
- County Medical Services Program
- Medicare/Medi-Cal crossover claims
- Out-of-state providers (border community providers are included)
- Pharmacy
- Laboratory
- Radiology
- Rural Health Clinics and Federally Qualified Health Clinics